RCOphth response to APPG for Health: Call for Evidence 2026

Inquiry on Improving Access to Primary Care

February 2026

Theme 1. Reducing Health Inequalities and Access Barriers

1) **What single policy change would most immediately improve patients' ability to be directed to the right primary care professional at their first point of contact, without the need for multiple appointments or repeated assessments and what evidence supports this?**

   Introduce and provide adequate funding to operate and sustain a single point of access (SPoA) model for all referrals between primary and secondary care within each integrated care system. This digital solution is proven to be effective at benefitting patients, ensuring that clinical triage results in a much higher proportion of patients directed to the right professional for treatment first time. This saves unnecessary hospital appointments, frees up capacity in the system and ensures a smooth and suitable treatment pathway for the patient.

   In ophthalmology, most referrals come from primary care optometrists. The most effective SPoA models foster collaboration between hospital eye services and primary care optometrists. Two-way feedback loops can help optometrists work to the top of their licence and enhance their learning and skills, ensuring an increasing accuracy of referrals.

   Research by the Royal National Institute of Blind People found that a national rollout of SPoAs would save up to £171 million annually. Effective SPoA models such as SPARC at Moorfields Eye Hospital in London, featured in a best practice case study for the Royal College of Ophthalmologists (RCOphth), drastically reduce referral time and enables patients with the most urgent needs to be prioritised. They should be replicated nationwide. Other benefits include more informed patient choice on initial provider preference and data-driven service improvement. Moorfields' SPoA rollout across North Central London (NCL) resulted in referral processing time reducing from 11 days to just 2-3 hours. It also improved capacity management – 58% of initially urgent referrals were safely downgraded to routine. Routing accuracy has increased, with 40% of referrals redirected to the most appropriate service following triage, and a further 11% returned to community optometry with advice. The enhanced professional learning training sessions are popular with optometrists, with 94% of attendees rating them as extremely or very useful.

2)

   a) **What practical steps are needed to ensure that digital booking, triage, and record-access systems (including the NHS App) deliver equitable access across GP, pharmacy, dentistry, and optometry services particularly for digitally excluded individuals, non-English speakers, older people, and visually impaired patients? Please include any case studies of effective practice.**

b) What hybrid access models are required to ensure digital systems and the shift from analogue to digital do not contribute to a two-tier model of access?

a) The 'Digitally optimising eye care referrals in West Yorkshire' case study describes how a digital referral and triage platform, supported by local optometry practices, tackled digital exclusion. Whereas previous referral systems created barriers for patients, especially those with profound sight loss, the new referral platform incorporated feedback from The Royal National Institute of Blind People, so that it could provide additional support to digitally excluded patients. This referral service found that 72% of advice requests did not require hospital referral, saving patients, many with sight loss, from making trips for unnecessary appointments. RCOphth's 'Reimagining macular referrals in Bristol' case study describes the effectiveness of the Enhanced Macular Referral Service. The pilot enabled community optometrists to send clinical details, scans and summary healthcare records of patients with macular diseases to hospital eye services for remote assessment. This helped three quarters of patients to avoid a hospital appointment. This is especially beneficial to older patients, who are likelier than any other age demographic to present with eye diseases or conditions. Hospital visits can be onerous and stressful for older patients with visual impairment, so this remote assessment service benefitted them in improving access to treatment while shortening the anxious wait for clinical opinion.

b) A significant portion of patients with chronic conditions, such as glaucoma and age-related macular degeneration (AMD), are particularly well-suited to treatment in community settings that are closer to their home and therefore more accessible for the patient than hospital eye services. These can be diagnostic centres operated by ophthalmology departments or optometry practices in primary care with oversight by the ophthalmology service. Integration between settings ensures consistency of care. RCOphth's position statement on shifting ophthalmology-led care from hospital to community settings outlines that enablers of success comprise:

- Appropriate governance and quality assurance arrangements, overseen by consultant ophthalmologists.
- Improved IT interoperability, underpinned by a SPoA model, to allow images and patient information to be transferred more easily between different settings and providers.
- Suitable facilities for diagnostic centres in communities, whether part of existing NHS estate such as spare rooms in GP surgeries, or retail premises.
- Robust strategic commissioning with effective oversight of capacity, standards and spend to provide locally-needed services that reduce health inequalities.
- Appropriate funding for enhanced optometry services and non-medical workforce training.

Theme 2. Harnessing Digital Transformation and System Integration

3)

a) What are the key structural or digital barriers that primary care providers face in achieving joined-up working and system integration, and what policy changes, innovations, or practical solutions would best support seamless and collaborative primary care?

A key barrier to offering patients equitable, timely eye care is poor interoperability between digital systems in different parts of the NHS estate. A 2024 survey of clinical leads in ophthalmology departments found that only 9% had well-functioning electronic patient record systems and 14% had well-functioning interoperable imaging standards.

Currently many optometrists and ophthalmologists lack access to complete electronic health records (EHRs), hindering communication and collaboration – especially when patients move between providers. This inefficiency in the patient pathway can result in delays to care, growing waiting lists, unnecessary referrals, manual re-entry of data and duplication of tests. It also raises the risk of misdiagnosis and treatment errors, compromising patient safety and contributing to professional frustration.

A modern, digitally-enabled and efficient NHS must provide better integration of primary and secondary services, with interoperable EHRs and shared imaging standards so that data can be passed seamlessly and accessed across the patient pathway. RCOphth's position statement on the standardisation of electronic health records in eye care was co-signed by The College of Optometrists as well as independent sector providers of services for NHS patients, demonstrating the agreement on how important it is to improve digital interoperability across all parts of the eye care system. Ensuring two-way communication and enabling all providers to access and update consistent EHRs is critical to delivering joined-up, high quality eye care.

b) What are the most significant barriers to interoperability across NHS digital systems and how can suppliers be better supported or required to enable real-time data exchange across all primary care providers?

EHR vendors are not currently obliged to align their software to national standards (such as Digital Imaging and Communications in Medicine (DICOM)).
This leaves primary care optometrists and dispensing opticians unable to access or update the Summary Care Record. To resolve this problem, policymakers should commission eye care information standards based on datasets developed by the Royal College of Ophthalmologists and The College of Optometrists, and require EHR vendors to align their systems with these standards.

4) How should transparency, safety, and public trust be maintained when deploying AI or virtual tools in primary care, and what governance and regulatory safeguards are required?

As eye care has a focus on image analysis, there are compelling reasons to think that artificial intelligence will have an increasingly large role to play, improving diagnostic accuracy and personalising treatment plans. Transparency, safety and public trust in primary care deployments of AI/virtual tools should be maintained through an iterative, evidence-led implementation model that includes routine audits, quality assurance and patient engagement to confirm that tools remain safe, effective and equitable in clinical and diagnostic settings. Regulatory approval should consider levels of clinical risk, allowing lower-risk AI-powered tools to reach NHS deployment faster. There is currently too sharp a regulatory jump between lower-risk (class i) and higher risk (class ii) devices. This incentivises manufacturers to design tools in ways that qualify for lower risk classification. Risk classification should accurately align with how tools are used within clinical settings, to prioritise patient safety. NHS organisations should play a clearer role in identifying when manufacturers are not meeting these regulatory obligations. There should be more clarity on how non-compliance is reported. Public trust depends on strong post-market surveillance including monitoring significant model updates that could change a tool's clinical performance.

5)

a) What national-level infrastructure, policy reforms or regulatory levers are required to ensure the implementation of shared patient records across GP, pharmacy, dentistry, and optometry services? Which governance bodies should oversee data sharing and record access?

Data governance and privacy frameworks must cover the collection, storage and analysis of patient data, with clear guidelines on data usage and sharing between patients, practitioners, regulatory bodies and technology providers.

Eye care providers must ensure that all relevant staff are trained to collect and input patient information into EHRs where appropriate, so that colleagues across the sector have access to information in the format they need to make sound clinical decisions.

As set out in RCOphth's position statement on the standardisation of electronic health records in eye care, policymakers should consult the eye care sector and agree on eye care information standards based on approved datasets and digital imaging and communications in medicine (DICOM) standards. They should also require EHR vendors to align their systems to the agreed standards.

Additionally, DHSC must set policy to ensure that primary care optometrists and ophthalmologists can access and update the same EHRs for every referred patient.